Washington State Health Care Authority

Public Employees Benefits Board Retreat

January 9, 2013

Washington State Health Care Authority

Public Employees Benefits Board Retreat

January 9, 2013
8:45 a.m. – 3:00 p.m.

Health Care Authority
626 8th Avenue SE
Sue Crystal Rooms A & B
Olympia, Washington

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Washington State Health Care Authority

AGENDA

Public Employees Benefits Board Retreat
January 9, 2013
8:45 a.m. – 3:00 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

Conference call-dial in: 1-888-450-5996, Participant Passcode: 546026

8:45 a.m.	**Welcome, Introductions**	MaryAnne Lindeblad, Chair
9:00 a.m.	**PEB Budget Update** - Governor's budget and process - PEBB health care cost trends	Annette Meyer, HCA Deputy CFO
9:20 a.m.	**Affordable Care Act – Impacts & Opportunities** - Non-Medicare retirees and the Exchange - Federal expectations of employers	Mary Fliss, PEB Division Deputy Director
9:50 a.m.	**PEB Portfolio Overview of Strategies**	Lou McDermott, PEB Division Director
10:00 a.m.	**Group Health Update** - Group Health changes - Network performance improvement	Fred Armstrong, GHC Patty McKeon, GHC Tom Paulson, GHC
10:30 a.m.	**Break**	
10:50 a.m.	**Kaiser Permanente Update** - Disease Management - Worksite Health Assessment Programs	Hilary Getz, KP Dr. Thomas Syltebo, KP Jeff Akers,KP Kay Zimmerli, KP
11:30 a.m.	**UMP Health Management Programs**	Scott Pritchard, PEB Division
12:10 p.m.	**Lunch**	

1:15 p.m.	**Regence Provider-focused Strategies** - Total Value Networks - Total Cost Care	Jonathan Hensley, Regence Beth Johnson, Regence
1:50 p.m.	**UMP Prescription Drug Benefit Update** - Value based prescription benefit - Future opportunities/considerations	Thad Mick, ODS
2:30 p.m.	**Community Initiatives – Puget Sound Health Alliance**	Michele Ritala, PEB Division
2:50 p.m.	**Discussion and Next Steps**	Lou McDermott, PEB Division Director
3:00 p.m.	**Adjourn**	MaryAnne Lindeblad, HCA Director

The Public Employees Benefits Board will meet Wednesday, January 9, 2013 at the Washington State Health Care Authority offices. The Board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW. Direct e-mail to: board@hca.wa.gov. Materials posted at: http://www.pebb.hca.wa.gov/board/

Washington State Health Care Authority

PEB Board Members

Name	Representing
MaryAnne Lindeblad, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1863 maryanne.lindeblad@hca.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Vacant*	K-12
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Lee Ann Prielipp 29322 6th Avenue Southwest Federal Way WA 98023 V 253-839-9753 leeannwa@comcast.net	K-12 Retirees
Vacant	Benefits Management/Cost Containment
Yvonne Tate Human Resources City of Bellevue PO Box 90012 Bellevue WA 98009-9012 V 425-452-4066 ytate@ci.bellevue.wa.us	Benefits Management/Cost Containment

PEB Board Members

Name	Representing
Marilyn Guthrie 4515 NE 71st ST Seattle WA 98115-6109 V 525-3690 Marilynguthrie52@gmail.com	Benefits Management/Cost Containment
Harry Bossi* 3707 Santis Loop SE Lacey WA 98503 V 360-689-9275 hbossi@comcast.net	Benefits Management/Cost Containment

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*non-voting members

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2013 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:00 p.m., unless otherwise noted below.

January 9, 2013 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 20, 2013

April 17, 2013

May 22, 2013

June 26, 2013

July 10, 2013

July 17, 2013

July 24, 2013

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

Washington State Health Care Authority

2014 PEBB PROCUREMENT CALENDAR

March 20	Board Meeting: Budget, Open Enrollment Summary, & Procurement Brief
April 17	Request for Proposals Issued to Fully-insured Plans
May 16	Proposals Due
May 22	Board Meeting: Initial Proposal Brief & Budget Update
June 26	Board Meeting: Procurement Update, Eligibility Scope, & Policy Brief
July 10	Board Meeting: Recommended Resolutions • Plan Design • Employee Premiums • Medicare Explicit Subsidy • Eligibility Policy (if needed)
July 17	Board Meeting: Resolution Vote
July 24	Board Meeting if needed

Updated 7/19/12

Washington State Health Care Authority

PEB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board's By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

Washington State Health Care Authority

PEBB Retreat – Financial Overview

Annette Meyer
Deputy CFO
Financial Services
January 9, 2013

Financial Objectives

- Continue to be a prudent purchaser of health care services and look for ways to balance the value of benefits purchased with the cost of services provided.
- To improve the value of the benefits provided, the HCA is exploring options related to member engagement, wellness, accountability, and value based benefit designs.
- Maintain cash flow solvency of the PEBB funds.

Governor's Budget Update

('**13 -15 Governor's Budget** – FY 2013 1st Quarter Projection Model 5.0)

	SFY 2014	SFY 2015
Funding rate	$809	$820
Retiree subsidy	$150	$150
K-12 remittance	$66.22	$71.76

	SFY 2013	SFY 2014	SFY 2015
Projected Ending Surplus/(Deficit)	$252	$164	$0

Health Care Trends

- Health care trends continue to outpace growth in domestic product.

- National health care premium trend estimates for CY 2013 vary:
  - **Aon Hewitt:** **Employer-Sponsored 6.3%**
  - **Segal:** **PPO/POS 8.8% HMO 7.9%**
  - **Pricewaterhouse Coopers:** **Employer-Sponsored 7.5%**

- The CY 2013 non-Medicare trend estimate for UMP benefits is **6.4%**. The corresponding trend estimate Medicare UMP benefits is **6.6%**.

- The CY 2013 non-Medicare and Medicare trend estimate for managed care premium is **7.5%**.

Non-Medicare expenditure trends continue to be volatile

Plan	09/08	10/09	11/10	YTD 12/11
UMP	14.1%	3.5%	-3.2%	5.4%
Group Health	9.0%	-4.3%	1.7%	7.0%
Kaiser	9.9%	12.8%	7.1%	.3%

Affordable Care Act Impacts

- Patient Centered Outcomes Research Fees
- Transitional Reinsurance Program Fees
- Pay or play penalty costs

Management Risks and Opportunities

- Risks
  - Projected trend differs from actual trend
  - PEBB revenue (funding rate) does not keep pace with medical inflation
  - ACA impacts
- Opportunities
  - Health management
  - Member engagement

Questions?

Annette Meyer, Deputy CFO

Financial Services

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Tel: 360-725-1277

Washington State Health Care Authority

Affordable Care Act Impacts & Opportunities

Mary Fliss
PEB Division Deputy Director
January 9, 2013

Purpose of this Briefing

- High-level information on:
  - what has been implemented
  - what is anticipated

Review

- Changed child eligibility to age 26
- Lowered the FSA contribution limits and changed how they can be used
- Worked with the 8 state payrolls to implement W-2 reporting
- Revised coverage for women's healthcare
- Produced the Summary of Benefits and Coverage

Looking Ahead

- Employer Notice regarding the Exchange
- Patient-Centered Outcomes Research Fee (PCOR)
- Transitional Reinsurance Assessment
- Retiree Deferral Rules
- Play or Pay

Pre-Medicare Retiree Deferral

- Current requirements
- Health Benefit Exchange 2014
- Potential revision to requirements

Play or Pay

- Current PEBB Eligibility Framework
- Federal Eligibility Framework
- Comparison
- Associated Penalty

Next Steps

- Pre-Medicare Retiree Deferral
  - Complete analysis
  - Work with stakeholders
  - Recommend in the 2013 PEB Board rule making

- Play or Pay
  - Complete analysis
  - Explore automation
  - Work with governor's office/OFM, agencies, and the Health Benefit Exchange
  - Potential eligibility recommendation in the 2013 PEB Board rule making

Questions?

Mary Fliss, Deputy Director,
PEB Division
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PEB Division
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Public Employees Benefits Board

2013 Annual Retreat

January 9, 2013

GroupHealth

Group Health Update

Presenters:

- Thomas Paulson, MD – Chief Medical Operations Officer
- Fred Armstrong – Director, Complex Accounts
- Patricia McKeon – Senior Account Consultant

Agenda:

- Group Health Changes
- Network Performance Improvement

Group Health Changes - Affordability

Focus on Cost Reduction:

- Reduce company wide operating expense by 7%
- Expense reduction changes to be implemented throughout 2013
- Quality performance not affected
- Targeted dollar reduction - $250 million
    a) 2012-2013 identified expense reduction - $150 million
    b) 2013 TBD expense reduction - $100 million

Group Health Changes - Quality

Group Health's commitment to quality is UNCHANGED:

- 2012 NCQA health plan accreditation - Excellent
- 2012 eValue8 results (WA carriers):
    a) Highest overall score
    b) Highest scores for Prevention & Health Promotion, Behavioral Health & Pharmaceutical Management
- Patient Centered Medical Home – level 3 NCQA recognition for Group Health Medical Centers (1 of 2 NCQA recognized group practices in WA)
- Puget Sound Health Alliance Community Checkup – Group Health Medical Centers highest ranked group practice

Group Health Changes - Quality

What's Noteworthy:

- 2013 CMS Medicare 5 Star rating (GHC 1 of 11 Medicare Advantage plans nationwide)
- Decision aids at Group Health linked to lower knee and hip surgery rates and costs – Health Affairs, September 2012
- Value Based Insurance Design – Group Health awarded $2 million by the Agency for Health Research and Quality (AHRQ) for a 4-year study on incentives to align care, coverage and wellness

Commitment for Innovation Unchanged

What's Noteworthy:

- Group Health is an active participant in the Puget Sound Health Alliance and during 2013 will be working closely with the Alliance in advancing its 2013 objectives:
    a) Reduce the COST/PRICE of health care services;
    b) Reduce OVERUSE of health care services; and,
    c) Reduce UNDERUSE of effective care

Commitment for Innovation Unchanged

What's Noteworthy (con't.):

- Group Health initiatives in place at least since 2010:
  a) Patient Centered Medical Home (version 2.0 in development)
  b) Hospital Transition Management
  c) Emergency Department/Hospital Inpatient – (Quality Compass utilization: Group Health's 2012 ED visits ranked in the lowest 5% nationwide)
  d) High end imaging

Commitment for Innovation Unchanged

What's Noteworthy (con't.):

- 2013 development work:
  a) Exchanges – preparing for 2014
  b) Enhanced "Population Health Management" capabilities
  c) Work site clinics
  d) Enhanced "Care management" capabilities
  e) Continued network development/improvement
  f) Specialty pharmacy

Network Performance Improvement

- **Recognition medical cost varies by region:**
    a) Facility expense is a primary driver
    b) Each region needs to be addressed separately
- **Multiple hospital contracts renegotiated in 2012**
- **Specific market focus in Spokane and Tacoma**
- **Aggressive utilization targets**

Questions

GroupHealth

WA PEBB Retreat
Kaiser Permanente

January 9, 2013

KAISER PERMANENTE® thrive

Discussion Outline

1. **Overview: Disease Burden/Lifestyle Risks**
2. Impact on Group
3. Identification and Disease Management
4. Prevention

KAISER PERMANENTE® thrive

Disease Burden/Lifestyle Risks

- Chronic Conditions
  - Higher than average prevalence of diabetes, hypertension and depression
- Prevention and Lifestyle Risks
  - 4 out of 10 in obese range
  - 9.5% severely obese

KAISER PERMANENTE® thrive

Discussion Outline

1. Overview: Disease Burden/Lifestyle Risks
2. **Impact on Group**
3. Identification and Disease Management
4. Prevention

KAISER PERMANENTE® thrive

Impact on Group

- Prevalence – changes over time (Chronic Conditions report)
- Cost implications of Diabetes (Chronic Conditions report)

Discussion Outline

1. Overview: Disease Burden/Lifestyle Risks
2. Impact on Group
3. **Identification and Disease Management**
4. Prevention

KAISER PERMANENTE® thrive

Identification and Disease Management

- Controversy around screening
- What are we doing at Kaiser Permanente?

- Goal oriented Cardiovascular Risk Reduction
- Control Blood Sugar, Blood Pressure, LDL (Chronic Conditions report)
- Screen for other complications: kidney, eye damage
- Early introduction of Insulin (new insulin start program)

KAISER PERMANENTE® thrive

Discussion Outline

1. Overview: Disease Burden/Lifestyle Risks
2. Impact on Group
3. Identification and Disease Management
4. **Prevention**

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Prevention

- Diabetes risk factors – Age and Obesity
- Obesity rates for WA PEBB, trending over time (PLR)
- Weight management interventions/importance of physical activity
- Exercise as a vital sign
- Worksite wellness

Washington PEBB Commercial
Prevention and Lifestyle Risks, and Chronic Conditions Reports
For the 12 month period ending June 30, 2012

DEMOGRAPHICS

	WA PEBB 12/31/2010	WA PEBB 12/31/2011	WA PEBB 6/30/2012	Group vs KP comparison
Subscribers	2,392	2,155	2,151	
Members	5,150	4,882	4,872	
% female	53.9%	53.7%	53.6%	1.8% pts higher
Average age	37.5	36.5	36.4	2.6 yrs older
Avg. family size	2.2	2.3	2.3	0.3 higher

- It is important to note that the membership results are slightly understated because of the use of HEDIS continuous enrollment rules, which exclude membership additions in most recent 12 month period.

- The group is **significantly older** than the Kaiser Permanente average commercial group, this despite a **higher average family size** (which means that the group has a higher proportion of children who would lower average age). Age is important because several health issues increase with age (obesity, cholesterol, and blood pressure) while smoking prevalence declines.

LIFESTYLE RISKS

Adult Weight Management (Ages 21-74); excludes those receiving maternity care
70% with weight/height recorded in past 12 months. **N=2,460**

	WA PEBB 12/31/2010	WA PEBB 12/31/2011	WA PEBB 6/30/2012	KPNW 6/30/2012
Underweight BMI <18.5	0.5%	0.4%	0.7%	0.8%
Normal BMI 18.5-24.9	23.8%	23.5%	23.7%	26.3%
Overweight BMI 24.9-29.9	31.6%	32.3%	32.8%	32.0%
Obese BMI 30+	44.1%	43.8%	42.8%	41.0%
Severely Obese BMI 40+	10.0%	10.2%	9.5%	9.0%

- **Obesity is a significant problem** for the group's adults. Over 4 out of 10 fall into the "obese" range and 9.5% are in the "severely obese category". The group's results are slightly worse than KP average, but we do see a trend towards improvement.

Childhood Weight Management (Ages 2-20); excludes those receiving maternity care. **N=659**

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/2012
Underweight BMI % <5.0	2.3%	2.8%	2.0%	2.4%
Normal BMI % 5.0-84.9	65.8%	64.9%	65.4%	65.4%
Overweight BMI 85.0-94.9	14.6%	15.8%	15.5%	15.7%
Obese BMI % 95.0+	17.3%	16.5%	17.1%	16.5%

- It is not surprising to see that the group's children also are suffering from obesity. **The strongest association for childhood obesity is parental obesity.**

Cholesterol Management (ages 18-75 with total cholesterol measured in past 5 years) **66%** in targeted membership with measurement. **N=2,498**

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/2012
Desirable Total chol <200	62.8%	62.5%	60.8%	61.2%
Borderline high T chol 200-239	28.2%	28.1%	29.8%	28.1%
High Total chol 240+	9.2%	9.4%	9.4%	10.7%

- Two out of three adults have had the recommended screening for total cholesterol. **Slightly under 10% fall into the "high" zone.** This is somewhat better than the KP average.

Blood Pressure Control (Ages 18-85) with BP recorded over past 12 months)
78% of targeted membership with recorded BP. **N=2,928**

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/2012
Normal BP <140/90	89.0%	88.9%	88.9%	88.8%
High 140/90+	11.0%	11.1%	11.1%	11.2%

- This measure looks at the last recorded blood pressure reading of the group's adults. About **11% had an elevated reading**. This was at the commercial average. It is a stable finding over the three reporting periods.

- 78% of the targeted membership is included in this measure. The percentage is a good surrogate for the proportion of adults who have had an outpatient visit over the past 12 months. This is somewhat higher than average (usually in the low 70s).

Smoking Status (Ages 18+)
96% with smoking status recorded. **N=3,623**

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/2012
Yes – I smoke	13.5%	13.9%	14.0%	16.3%
No - I do not smoke	86.5%	86.1%	86.0%	83.7%

- **Smoking cessation** is a worthwhile intervention to promote. Cessation is associated with improved health and decreased costs; both direct – medical claims, and indirect – absenteeism and disability. These improvements are seen in 1-2 years after stopping smoking.

- Smoking rate has shown a **slight increase** over the past several years. This is unusual as for the overall commercial population, there has been a gradual decline (0.5-1% point down each year for the past 3 years). This increase may be influenced by the addition of young adults as dependents (an impact of healthcare reform), but this has not been seen with other groups.

PREVENTION SERVICES

	WA PEBB 12/31/2010	**WA PEBB 12/31/2011**	**WA PEBB 6/30/2012**	**KPNW 6/30/2012**
Childhood immunization	90.7%	90.2%	88.1% >90th percentile	84.9%
Breast cancer screening	86.6%	85.7%	85.1% >90th percentile	79.3%
Cervical cancer screening	88.9%	88.8%	85.6% >90th percentile	84.5%
Colorectal ca screening	74.8%	76.0%	74.0% >90th percentile	72.4%

- Kaiser Permanente reports **group-specific results** when there are at **least 30 members** in the measure.

- **Childhood immunization** looks at completion rates for toddlers between 18 and 24 months. There has been a very slight decline in the rate for these toddlers but it is still significantly above the KP commercial average and is **above the 90th percentile.**

- All of the **cancer screening** activities are also **above the 90th percentile** and higher than the KP commercial average.

- Above the 90th percentile means that the group's results are in the top 10% as compared to national results for non-PPO health plans, based on NCQA/HEDIS methodology.

MAJOR CHRONIC CONDITIONS

Prevalence (as defined by HEDIS)

	WA PEBB 12/31/2010	WA PEBB 12/31/2011	WA PEBB 6/30/2012	KPNW 6/30//2012
Diabetes	5.1%	5.3%	5.6% N=244	4.4%
Depression	6.6%	7.1%	7.1% N=310	6.0%
CAD *	0.8%	0.6%	0.6% N=25	0.5%
Heart Failure	0.3%	0.3%	0.3% N=11	0.4%
Asthma	0.7%	1.1%	0.9% N=40	1.1%
Hypertension	6.8%	7.3%	6.7% N=293	5.1%
Maternity	1.7%	1.8%	1.7% N=82	2.2%

CAD * = Coronary Artery Disease

- **Prevalence** rates use the entire population in the denominator, so groups with higher than average family size (more children) have chronic conditions understated because this conditions are essentially adult diseases.

- Despite Washington PEBB falling into this category, we see **higher than average** prevalence of **diabetes, depression, and hypertension.** All of these conditions increase with advancing age. Diabetes and hypertension are also influenced by obesity. Thus it is not surprising to see these results.

- **Maternity** is associated with younger populations, thus the lower than average prevalence fits the group's demographics.

- The prevalence of **CAD, heart failure and asthma** are too small to draw any conclusions.

Outcomes (using NCQA/HEDIS methodology)

Hypertension

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/12
Adequate control BP <140/90	75.8%	80.5%	83.3% >90th percentile	77.6%

- We see a **steady improvement** of blood pressure control for the group's members with hypertension. The current result is better than the commercial average and **above the 90th percentile.**

Diabetes

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/12
Screened HbA1C	97.2%	95.8%	96.3% >90th percentile	94.1%
HbA1C poor control (>9%)	18.8%	21.8%	23.4% <75th percentile	22.9%
LDL chol < 100	62.0%	60.9%	57.8% >75th percentile	56.1%
Eye exam	80.2%	79.0%	79.9% >90th percentile	72.9%
Nephropathy monitoring	93.6%	95.8%	95.9% >90th percentile	92.7%
BP <130/80	48.8%	46.2%	45.9% >90th percentile	46.3%
BP <140/90	83.6%	79.8%	83.2% >90th percentile	80.8%

- Quality measures for **diabetes** look at control of **blood sugar**, **LDL (bad) cholesterol**, and **blood pressure.** We see excellent results for blood pressure control, good cholesterol levels, and the need for improvement for blood sugar control. Eye exam and nephropathy monitoring look for complications associated with diabetes (eye and kidney damage). We see excellent results for both.

Asthma

	12/31/2010	12/31/2011	6/30/2012	KP 6/3012
Use of controller medication	91.2%	95.9%	100% >90th percentile	93.9%

- Excellent results are seen in the management of persistent asthma.

Depression

	12/31/2010	12/31/2011	6/30/2012	KP 6/30/12
Use of generic antidepressant	96.2%	96.7%	98.2%	97.0%
Effective acute phase treatment	67.3%	82.4%	80.9% >90th percentile	77.5%
Continuation phase treatment	52.7%	64.7%	63.8% >90th percentile	60.8%

- Once antidepressants are chosen to be started, it is important to have the patient use the medication for at least 6 months. The **acute** and **continuation phase** treatment assesses ongoing treatment. Both measures are **above the 90th percentile.**

Washington State Health Care Authority

UMP Health Management Programs

Scott Pritchard, M.S.
Health Management
Public Employees Benefits
January 9, 2013

Health Management Programs

These Health Management programs are currently being reviewed:

- Diabetes Prevention Program (DPP)
- Diabetes Control Program (DCP)
- Living Well with a Chronic Condition
- Weight Management

Diabetes Prevention Program

Health Issue:

- Reducing the conversion rate of people with pre-diabetes to diabetes

Expected Outcomes:

- 5% weight loss = 58% reduction in conversion to diabetes
- Reduces the annual 10% conversion rate pre-diabetes to diabetes

Diabetes Prevention Program

Program Description:

- A 16 session evidence-based program that addresses multiple components of weight loss and maintenance
- Delivered through a Center for Disease Control and YMCA partnership with UnitedHealthCare
- Contracted through Regence

Diabetes Prevention Program

Potential Number of Participants:

- 35% of PEBB members (18 and over) could be pre-diabetic (blood sugar 100-125)
- Engagement:
  - 80% of those who test positive at worksite testing event
  - 12.6% of those reached with a letter and phone call

Diabetes Prevention Program

Program Cost:

- Pay for Performance based on
  - Participation and meeting weight loss goal
  - Maximum cost: $590
  - Average cost $440

Diabetes Control Program

Health Issue:

- Nationally, less than 2% of people with diabetes are achieving good control

Expected Outcomes:

- Reduce blood sugar, blood pressure, and LDL cholesterol
- Decrease eye, kidney, nerve, and cardiovascular complications

Diabetes Control Program

Program Description:

- 4 one-on-one sessions with a specifically trained pharmacist (Safeway)
- Pharmacist coordinates with primary care provider, monitors medications, blood pressure, weight, and lab tests

Diabetes Control Program

Potential Number of Participants:

- 8-11% of population have diabetes
- Vendor estimates 21,000+ w/diabetes
- Vendor estimates 7,000+ will participate

Program Cost:

- Pay for Performance model
- Consult plus meeting blood sugar, LDL, and weight goals
- Average payment per participant is $750

Living Well with a Chronic Condition

(Chronic Disease Self-Management Program)

Health Issue:

- Self-management of a chronic condition(s)

Expected Outcomes:

- Health: increased energy, more exercise, fewer social limitations, better psychological wellbeing, enhanced partnership with physicians, improved health status
- Healthcare Utilization: reduced ER use, fewer hospitalizations, fewer days in the hospital

Living Well with a Chronic Condition

Program Description:

- Led by certified lay person with a chronic condition (certification by Stanford University)
- 6 structured sessions with participant interaction
- Issues addressed: cognitive symptom management, exercise, nutrition, sleep, medication, managing emotions, communicating with health professionals

Living Well with a Chronic Condition

Potential Number of Participants:

- Anyone with a chronic condition
- Most common: arthritis, blood pressure, chronic pain, depression, high cholesterol, diabetes, heart disease, asthma, COPD….

Program Cost:

- $50 per session, 6 sessions

Weight Management

Health Issue:

- 63% of PEBB enrollees (18 and over) are likely overweight or obese

Expected Outcomes:

- Reduction in the percent of the population that is overweight or obese
- Health status improvement for those that participate
- Reduction in health issues and costs linked to overweight and obesity

Weight Management

Program Description:

- Onsite and online programs
- A focus on healthy diet and physical activity
- User friendly food and exercise tracking tools to teach the relationship between food and exercise

Weight Management

Potential Number of Participants:

- Weight Watchers experiences a 4-5% uptake with a 50% subsidy
- Oregon experienced a 10% uptake with a 100% subsidy
- PEBB can choose the target population
  - Example: Provide subsidy for members over a threshold BMI of 27 (the lower level of overweight)

Questions?

More Information:

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Regence Provider-Focused Strategies

PEB Board Meeting Presentation

January 9, 2013

Regence Provider-Focused Strategies

- Intensive Outpatient Care Program (IOCP)
- Total Cost of Care
- Centers of Distinction – Total Value Contracts
- PCP Select / Accountable Care

Regence

Regence Cost and Quality Initiatives for PPO Plans

- Blue Distinction Centers of Excellence/Total Value Contracts
  - *Benefit design steerage towards high quality providers with demonstrated cost efficiency for high cost procedures*
- Intensive Outpatient Care Program (IOCP)
  - *Unique provider-led care management model for highest risk membership at urban/large providers*
- Total Cost of Care
  - *Reimbursement model based on cost and quality to introduce population management accountability*

Blue Distinction Centers (Quality)
Blue Distinction Centers+ (Quality + Cost)

- Designation given to healthcare facilities for their distinguished care in the areas of:
  - Bariatric surgery
  - Cardiac care
  - Complex and rare cancers
  - Knee and hip replacement
  - Spine surgery
  - Transplants

- Designations can be used in benefit designs to steer members to centers of excellence for care

Regence

Intensive Outpatient Care Program (IOCP)

- Complex care medical home
  - Target predicted highest cost 5-15% of population
  - Dedicate RN Care Manager → hub of patient-centered care team
  - Shared *(MD+RN+Member)* care plans, increased access, proactive management
- Quality-based care management payments
  - HEDIS outcome and program process measures
- Regence/Provider collaboration
  - Clinical and financial reporting *(Regence)*
  - RN Care Manager training and development *(Regence/Consultant)*

Total Cost of Care (TCC)

- Reimbursement mechanism for focusing clinical groups
  - Whole-person, whole-system cost accountability
  - Population management
  - Full panel
- Contract supported by provider-facing comprehensive reporting
- Necessary building block to long term accountable care strategy

Regence

PCP Select Overview

- Product and benefit driven solution
- PCP selection
- Strong benefit differentials
- Risk sharing continuum
- Quality integrated with reimbursement
- Build a comprehensive primary care system
  - Risk stratified population management
  - Planned care for chronic conditions and preventive care
  - Coordination of care across the medical neighborhood

Regence

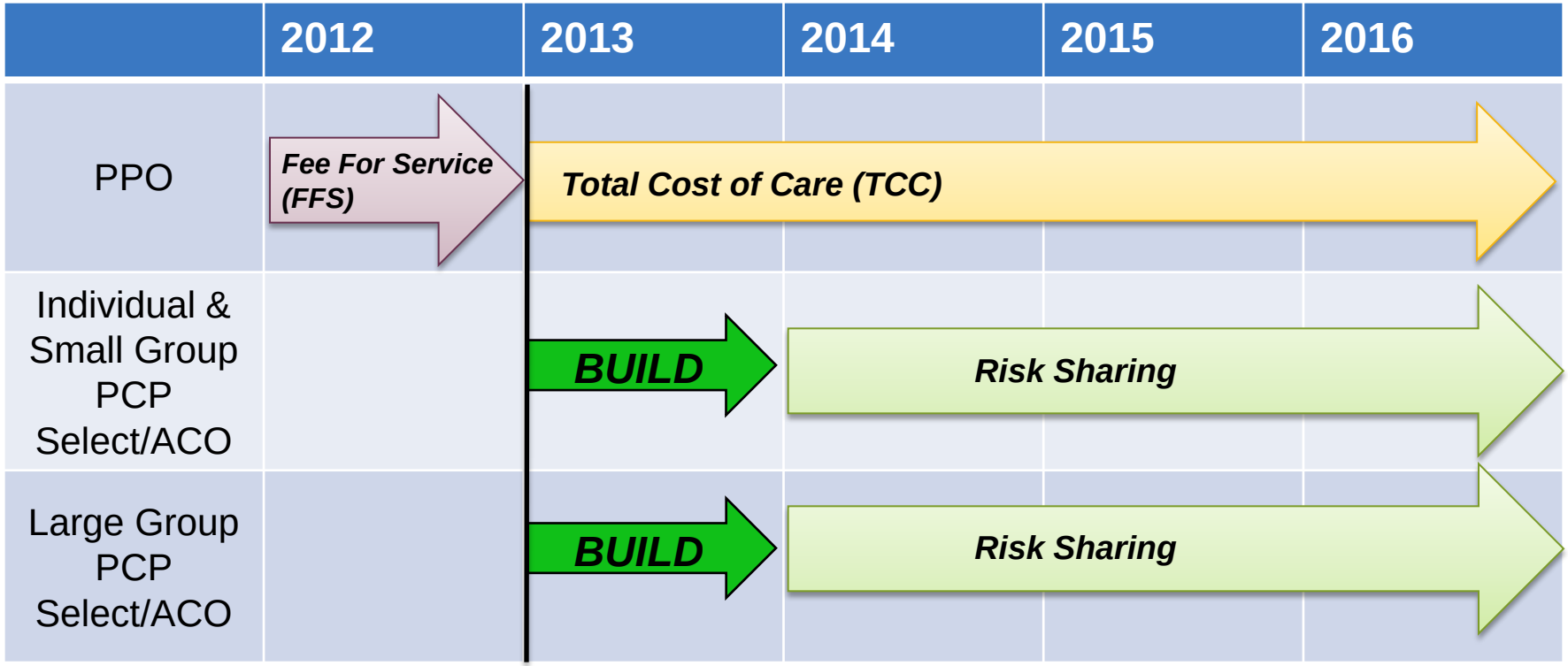
Building on Strong Foundation of IOCP to Increase Quality and Reduce Cost for More Members

	Current Providers	Planned Providers	Quality Measures	Launch Dates	Potential Geographies
IOCP	5	7	6	Current	Urban/Large Providers
Total Cost of Care	2	17+	16	2013	All WA
PCP/ACO Plans	0	TBD**	16	2014	All WA

**Volume dependent on market conditions and employer participation*

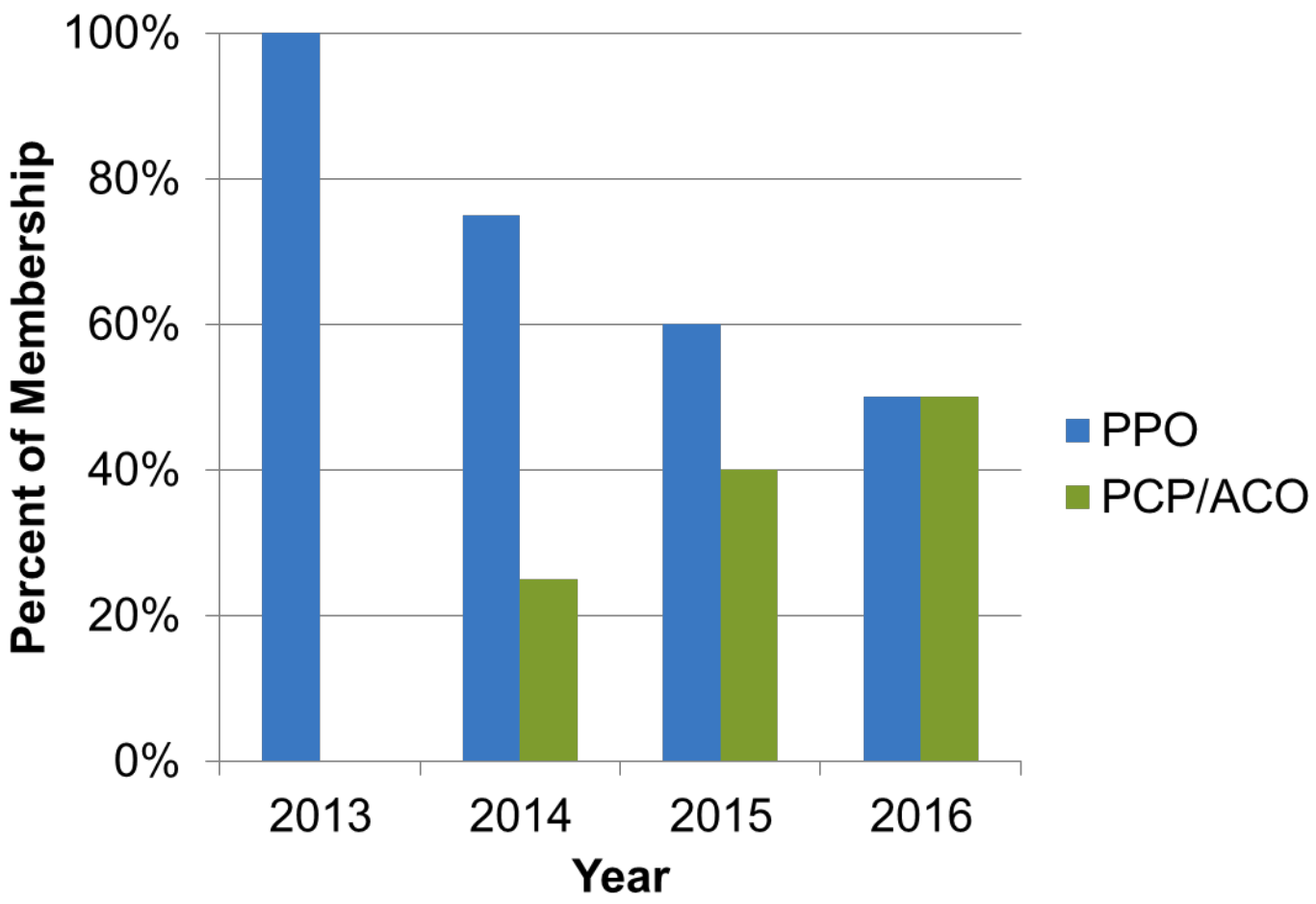
Regence

Product and Network Strategy Roadmap



Regence

Market Transition – Volume is illustrative



Regence

Manage Populations in ALL Lines of Business

- Specific solutions by product and market types
  - Total Cost of Care Incentives for PPO Attributed Members
  - Risk share for ACO/PCP Directed Members
- Develop tools to support provider and member cost effective health care decisions
  - Members: MyRegence.com
  - Providers: MyRegenceHealthcareBlueBook.com
- Robust financial and quality reporting

Regence

Expanded Provider Reporting for Care Management

- Provider Dashboard
  - Summarized financial and demographic information for Clinic and Benchmark
- Financial Settlement Reports
  - Monthly financials, Large Claimant Report, Member Census
- Historical Trend reports by Service Category
- Member Census
- Claims Reports vs. benchmarks
  - Milliman Health Cost Guidelines (Cost & Utilization Report)
  - Site of Service Report
- Investing to expand reporting capabilities

Regence

HCA Partnership Opportunities

- Blue Distinction Centers of Excellence
  - Benefits to support steerage by service
- Intensive Outpatient Care Program
  - Pay PMPM fees
- Total Cost of Care
  - Pay Risk Sharing Settlements
- PCP Select/Accountable Care
  - Benefit/Product to support steerage by Coordinated Care Networks
  - Pay PMPM fees
  - Pay Risk Sharing Settlements

Regence

Collaborative Innovations for Prescription Drug Benefits

Tailored strategies to deliver access, ensure quality & maintain affordability

January 9, 2013

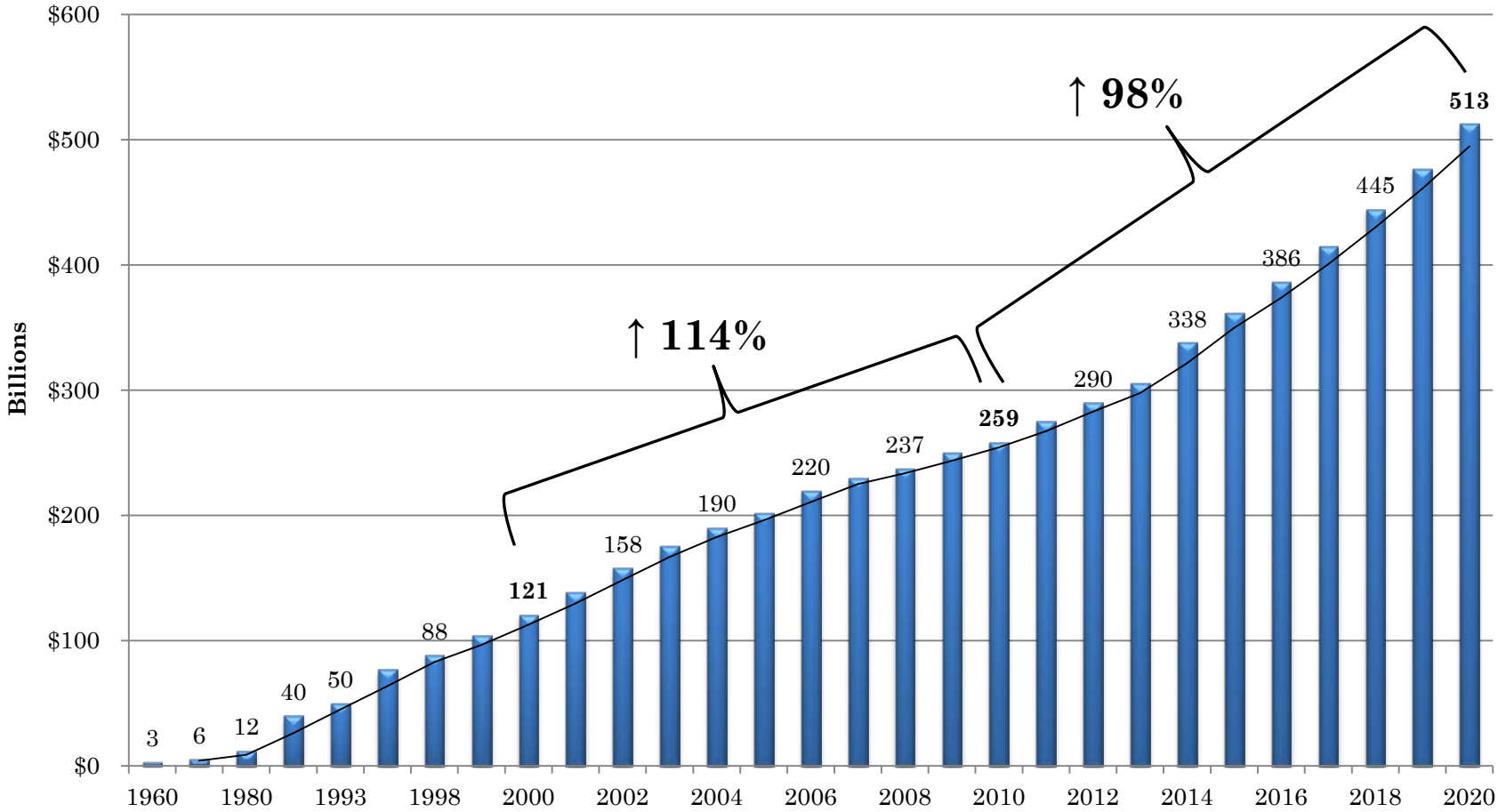
WASHINGTON STATE PRESCRIPTION SERVICES

ODS

National Pharmacy Market Trends

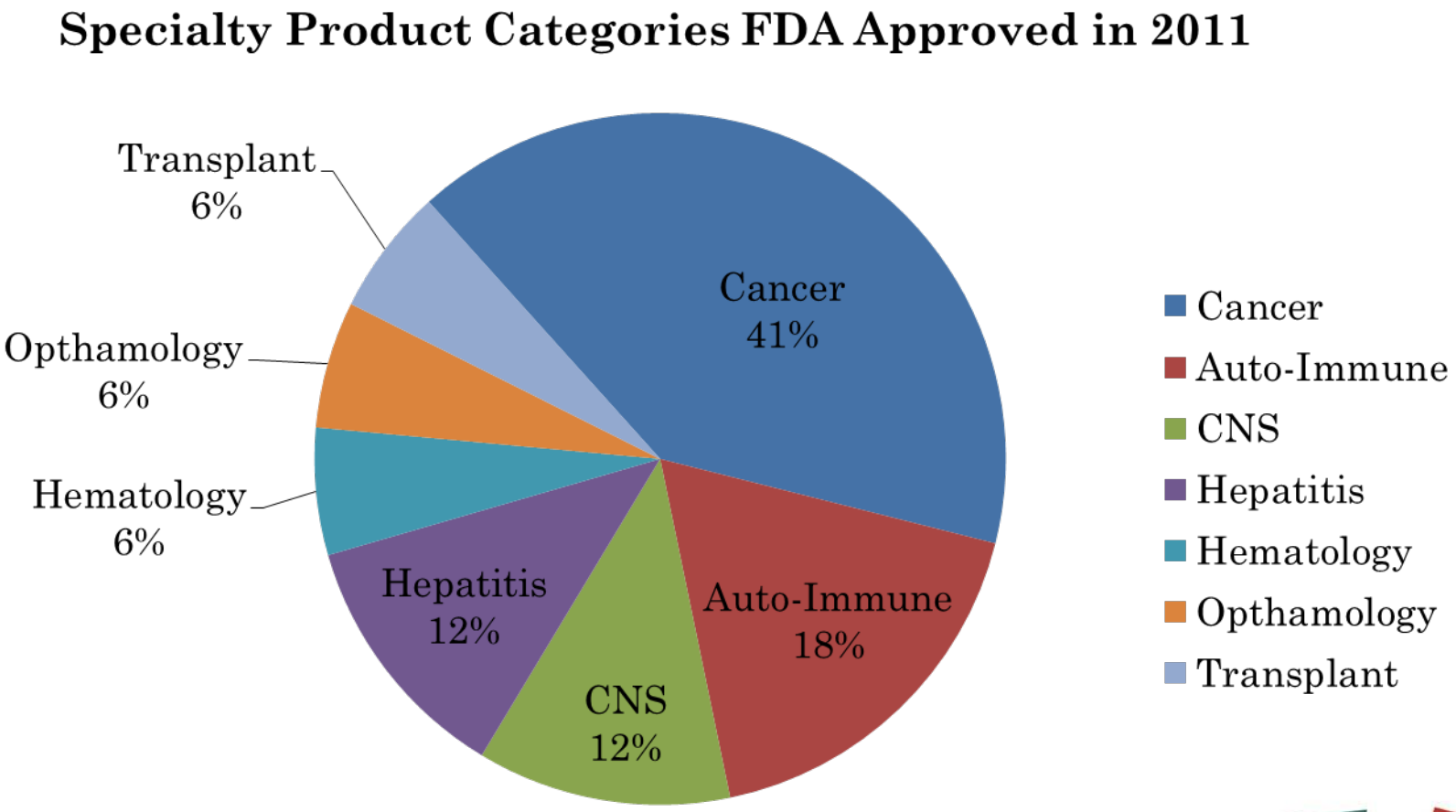
- Annual expenditure increases
  - New drugs
  - Generic pipeline
- Specialty drug costs: Average $2,000/month
  - Increasing by 15-20% per year
  - New oral specialty drugs
- Goals
  - Deliver access
  - Ensure quality
  - Maintain affordability for state & members

National Prescription Drug Trends



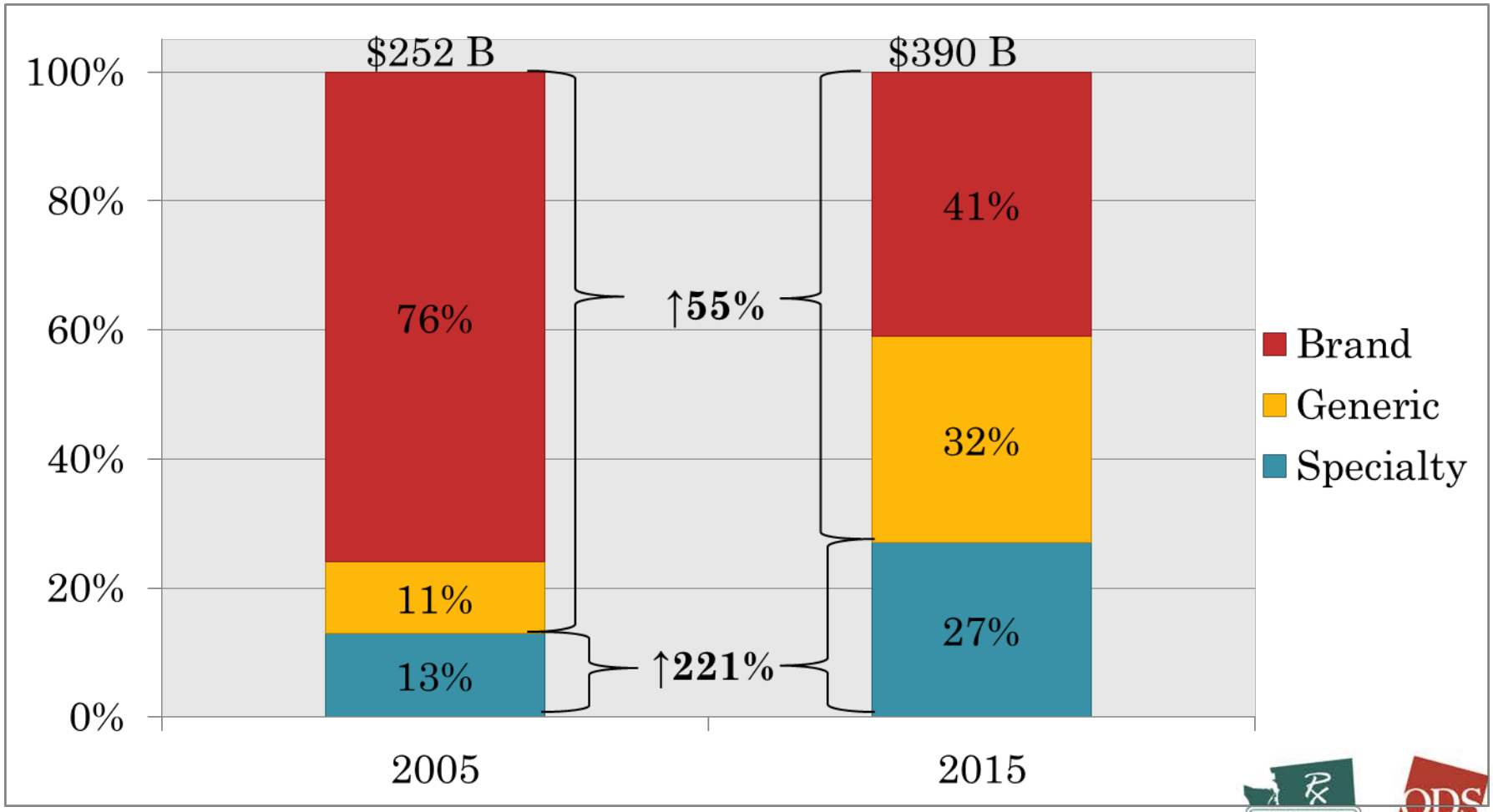
- CMS. National Health Expenditure Projections 2010-2020. https://www.cms.gov/nationalhealthexpenddata/downloads/proj2010.pdf
- CMS. National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth: Selected Calendar Years 1960-2009. https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf

New Molecular Entities



- 2012 Specialty Pharmaceuticals: Facts, Figures and Trends. Center for Healthcare Supply Chain Research.
- U.S. FDA, *New Molecular Entity Approvals for 2010.* www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/DrugandBiologicApprovalReports/ucm242674.htm

Prescription Spend Distribution



2011 Insights. Advancing the Science of Pharmacy Care: Changing Rules Changing Roles (http://info.cvscaremark.com/files/reports/Insights2011.pdf)

Value Tier - Goals

- Enhance access to cost-effective medications for common chronic diseases
  - Heart conditions
  - High blood pressure
  - High cholesterol
  - Depression
  - Diabetes
- Improve medication adherence
- Avoid unnecessary medical costs and emergency room visits
- Encourage member engagement

Value Tier Utilization & Success

	Before Implementation	After Implementation	Difference
AVERAGE COSTS			
Member Contribution	16% 30 day supply	5% 30 day supply	-11%
UMP Payment	$5.35 / 30 day supply	$6.24 / 30 day supply	+ $0.89
MEDICATION POSSESION RATIO (MPR)			
Cardiac	0.90	0.91	IMPROVED ADHERENCE (National Goal is 0.80)
Depression	0.86	0.88	
Diabetes	0.86	0.88	
Hyperlipidemia	0.90	0.91	
Hypertension	0.91	0.92	

Split Fill Program

- Goals
  - Enhance patient and physician support
  - Reduce medication waste
  - Savings to members and Uniform Medical Plan

- Treatments
  - Current specialty drugs in the following classes:
    - Oral oncology
    - Oral hepatitis C

Split Fill Program (continued)

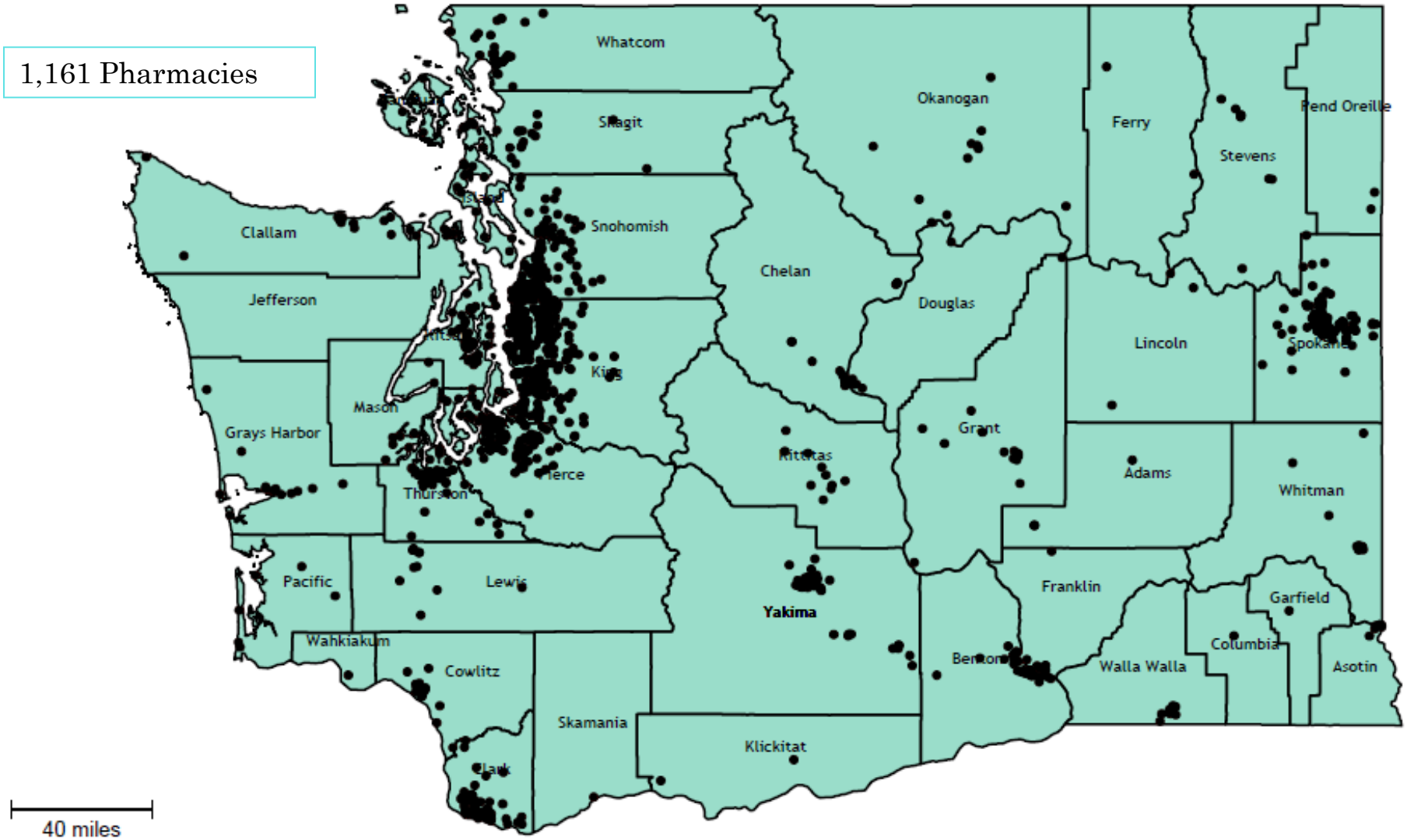
- How program works
  - Members receive up to a two-week supply during the initial 90 days of treatment
  - Provides high clinical touch
  - Specialty pharmacy
    - Contacts member for each refill
    - Screens for adverse events
    - Provides medication and treatment education
    - Coordinates treatment plan with providers

Pharmacy Network

- Collective purchasing volume
  - Northwest Prescription Drug Consortium
    - Washington Prescription Drug Program
    - Oregon Prescription Drug Program
      - 54,000 pharmacies nationally
      - 1,200 pharmacies in Washington
      - 600 pharmacies in Oregon
- Improve purchasing power
- Increase savings

Network Retail Pharmacies

1,161 Pharmacies



Pharmacy Vaccine Program

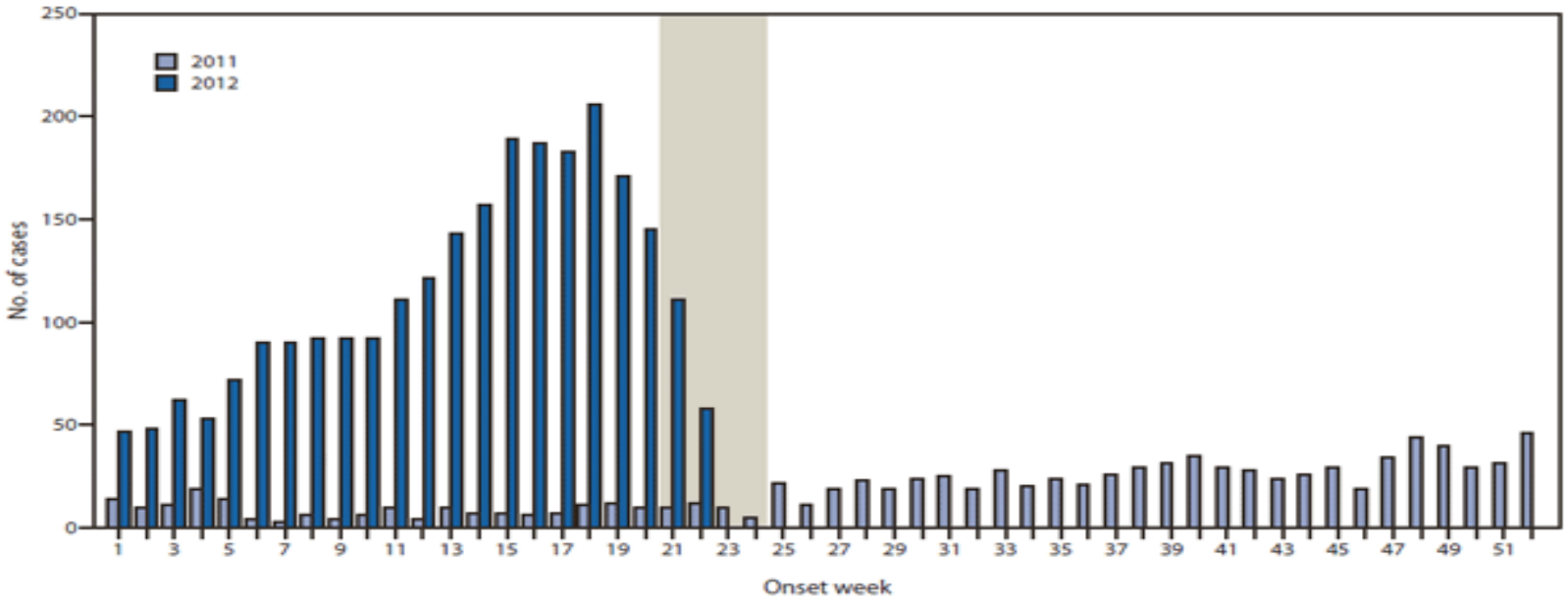
- Point-of-service vaccine benefit offering unprecedented access to immunizations and vaccines
- No physician appointment required

-Haemophilus B (HIB)
-Hepatitis A & B
-Human Papillomavirus (HPV) Vaccine
-Influenza
-Japanese Encephalitis*
-Measles, Mumps, Rubella (MMR)
-Meningococcal
-Tetanus, Diphtheria (Td) and Pertussis (Tdap)
-Pneumococcal (Pneumonia)
-Polio
-Rabies
-Shingles (Herpes Zoster)
-Typhoid*
-Varicella (Chicken Pox)
-Yellow Fever*

**Travel vaccines are accessible through retail pharmacies but are not covered by UMP.*

Vaccine Utilization

Number of confirmed and probable pertussis cases reported, by week of onset Washington, January 1, 2011–June 16, 2012*



UMP Tdap Pharmacy Vaccinations (ages 10 & older)

Year	Unique members	Tdap vaccines
2010	337	339
2011	620	621
2012**	6,848	6,867
Total	**7,805**	**7,827**

* *Centers for Disease Control and Prevention* ****Through November 2012*

Questions

Washington State Health Care Authority

Community Initiatives

Puget Sound Health Alliance & PEBB

Michele Ritala
Public Employees Benefits Division
January 9, 2013

Purpose of Briefing

- Summarize Alliance initiatives for 2013 and HCA/PEB Division participation

Puget Sound Health Alliance Background

- Started in late 2004
- Focused on health care quality reporting and performance improvement
- 165+ member organizations include employers (purchasers), providers, health plans, and consumers
- The Alliance is a neutral convener and change agent. It's up to member organizations to take action.

Alliance—The Next Five Years

Three goals in priority order

1. Reduce the cost/price of health care services
2. Reduce overuse of health care services
3. Increase use of effective care

#1 Reduce Price/Cost of Care

- Price Transparency Task Force: Measure variation in pricing between delivery systems for common hospitalizations
  - Report based on aggregated pricing data from payers
  - Combined with quality metrics to arrive at value
  - Reports distributed first to purchasers and payers
  - Limited access to providers
- Develop Purchaser Strategies

Timeline for Price Transparency

Now

- Health plans and other data suppliers signing data supplier agreement
- Begin providing data for report

March - May

- Data processing & analysis by Milliman
- Report released to Purchasers (who are Alliance members)
- Providers (who are Alliance members) receive only their results

June - Dec

- Alliance & Purchasers develop strategies
- Purchasers, Health Plans, Providers implement

#2 Reduce Overuse of Care

- Resource intensity reports and pricing data identify unwarranted variation
  - Purchasers & Alliance develop strategies to reduce variation
  - Engage with select delivery systems
- “Choosing Wisely” consumer engagement campaign

Choosing Wisely®

An initiative of the ABIM Foundation

ConsumerReportsHealth

American Academy of Allergy Asthma & Immunology

ABIM FOUNDATION

Allergy tests

When you need them—and when you don't

Skin or blood tests, when combined with a doctor's examination and your medical history, can help determine if you're truly allergic to something you inhaled, touched, or ate. But if you don't have symptoms or a medical evaluation that points to an allergy, you should think twice about testing. Here's why.

Random allergy testing usually doesn't help. You can now get allergy tests in places outside the doctor's office. Many drugstores and supermarkets, for example, offer free screenings. And you can even buy kits to test yourself at home. But random allergy testing may detect responses in people who don't have the same reaction in everyday life. In addition, screenings for food allergies sometimes use a blood test for a protein called immunoglobulin G (IgG). But those allergies are related to a different protein, IgE, and the usefulness of the IgG test to detect food allergies is unproven. Finally, allergy testing usually doesn't help people who have chronic hives—red, itchy, raised areas of the skin that last for more than six weeks—since those rarely stem from allergies.

Unnecessary tests can lead to unnecessary changes in your lifestyle. You might give up certain foods, such as wheat, soy, eggs, or milk, end up with nutritional problems, and be unnecessarily worried when dining out or buying groceries. A mistaken warning about allergy to pet dander might make you give up your dog or cat. And an aggressive workup for hives may show abnormalities that are unre-

Examples Campaign Materials

Bone density testing

Cancer Tests and Treatments

Chest X-rays

Imaging Tests

Imaging for headaches

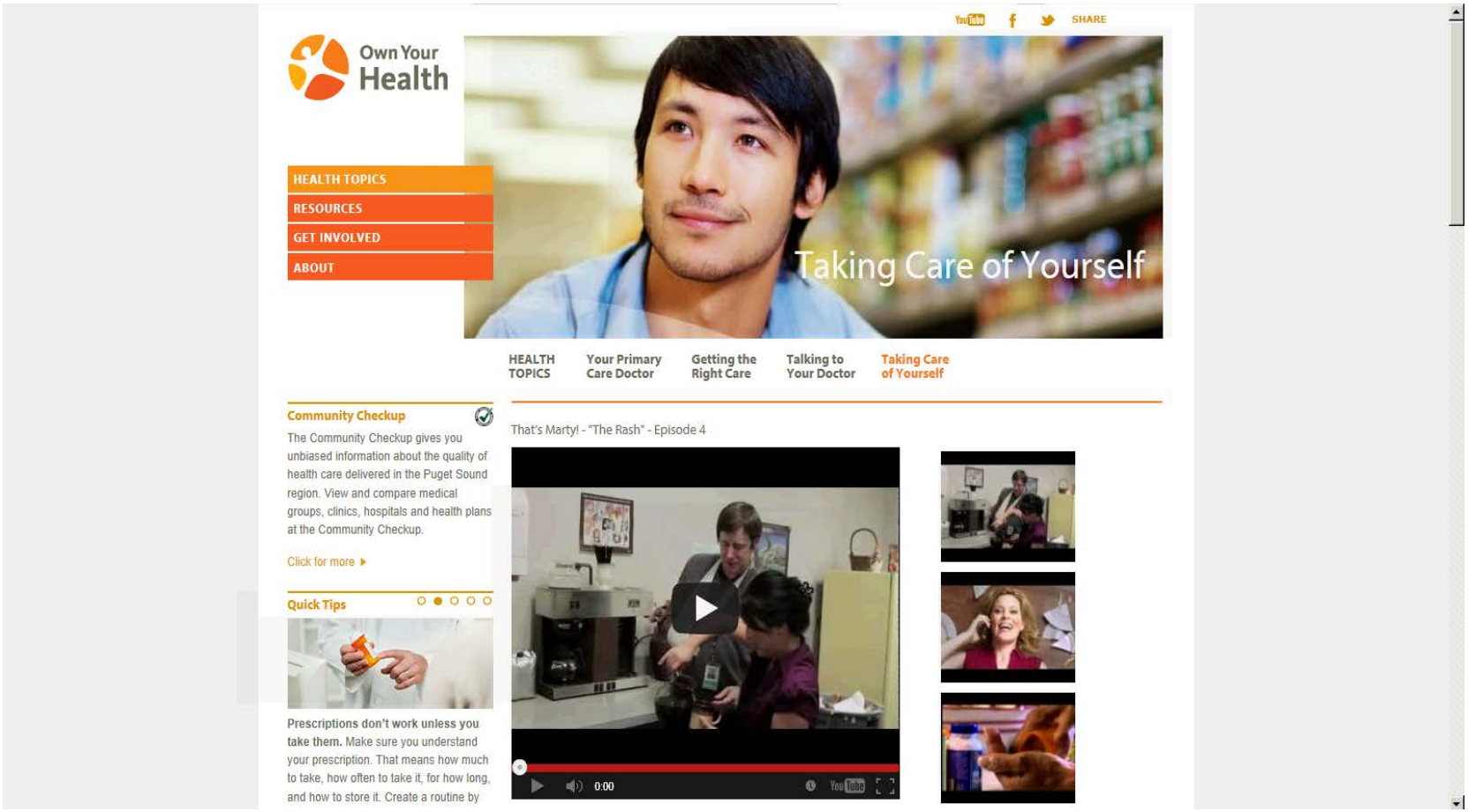
Painkillers

When to say "Whoa" to doctors

#3 Increase Use of Effective Care

- Multi-payer Patient Centered Medical Home project
- Statewide expansion of Community Check up report
- “Own Your Health” campaign to PEBB members
  - Importance of having primary care provider

Own Your Health



Washington State Health Care Authority

Resources

PSHA: www.pugetsoundhealthalliance.org
Community Check up: www.Wacommunitycheckup.org

Choosing Wisely: consumerhealthchoices.org/campaigns/choosing-wisely/
Own Your Health: www.WAcommunitycheckup.org/ownyourhealth/

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